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Medicaid Graduate Medical Education Payments: A 50-State Survey

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Questions about the contents of this publication may be directed to Lori Mihalich-Levin, Association of American Medical Colleges, at lmlevin@aamc.org, or Tim Henderson, health workforce consultant, at TimMHend@aol.com.

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Medicaid Graduate Medical Education Payments: A 50-State Survey

Tim M. Henderson, M.S.P.H.
Health Workforce Consultant

2013

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Introduction

States are an important source of support for physician training. State and local governments, as well as parent universities of medical schools in these states, appropriate funds for undergraduate medical education (\$4.7 billion in FY 2010¹), and Medicaid programs in many states help offset a portion of graduate medical education (GME) costs incurred by teaching hospitals and other entities.

Medicaid accounts for about one in six dollars spent on health care, is the largest source of federal funds to states, and covers medical and long-term care services for more than 62 million people.² By 2012, Medicaid represented the single largest program in the states, amounting to nearly one-quarter of all state spending and, for the first time, eclipsing spending for elementary and secondary education.³ After experiencing the impacts of the worst economic downturn since the Great Depression, state policy makers were finally beginning to see signs of economic recovery at the end of state fiscal year (FY) 2012 and heading into FY 2013. State revenue growth was positive, and neither Medicaid spending nor enrollment was growing at the high rates seen only a few years before. While cost pressure and cost containment were still dominant themes,⁴ states were also able to consider various program changes, including payment reforms. Moreover, federal spending is due to increase in 2014 when Medicaid coverage expansions are implemented under the 2010 Affordable Care Act.⁵ However, some federal deficit reduction proposals would significantly reduce Medicaid funding.

While Medicaid programs are not obligated to pay for GME, most states historically have made such payments under their fee-for-service programs.⁶ Medicaid is the second largest explicit source of funding (behind Medicare) for GME and the other special missions and services of teaching hospitals.⁷ Contrary to Medicare, the federal government has no explicit guidelines for states on whether and how their Medicaid programs should or could make GME payments.

In addition, many states have Medicaid managed care programs that provide some level of GME support. More than two-thirds of Medicaid beneficiaries are enrolled in comprehensive managed care programs, including risk-based managed care organizations (MCOs) and primary care case management programs. In FY 2013, 35 states plan to

¹ Such funds are non-Medicaid appropriations. Association of American Medical Colleges. *2012 Data Book*. Table D2.

² Jointly financed by the federal government and the states (federal government pays at least half the costs), Medicaid is run by the states that choose to participate (all have done so since 1982) within broad federal guidelines. After meeting federal requirements, states are able to determine key elements of their Medicaid programs, including who is eligible, what benefits are offered (such as payment for GME costs), and how much providers are paid. The result has been wide variation in Medicaid programs across the country. Medicaid funds more than 40 percent of all long-term care services (reflecting the record aging population entering nursing homes), and pays for 40 percent of all births and 17 percent of all health care services in the United States. Federal and state Medicaid spending has nearly doubled in the past decade, totaling in 2010 nearly \$390 billion, of which about two-thirds paid for acute care services and one-third went to long-term care services. <http://www.kff.org/medicaid/upload/8380.pdf>

³ The Fiscal Survey of the States, fall 2012. <http://www.nga.org/files/live/sites/NGA/files/pdf/FSS1212.PDF>

⁴ For FY 2013, at least 11 states proposed additional payment rate restrictions for Medicaid providers. A number of states also proposed changes to Medicaid reimbursement methods or other payment reforms. <http://www.kff.org/medicaid/upload/8380.pdf>

⁵ While the 2012 decision of the U.S. Supreme Court left the Affordable Care Act (ACA) and Medicaid eligibility expansions intact, the Court ruled that states will no longer be penalized for not expanding their Medicaid programs starting in 2014. The federal government will finance 100 percent of the expansion costs during the period 2014-2016. Despite this incentive, some states are likely not to expand Medicaid enrollment due to doubts about the reliability of federal funding and other concerns. The Court's decision does not affect the scheduled reductions in federal matching funds for payments to Medicaid disproportionate share (DSH) hospitals under ACA beginning in 2014. <http://www.kff.org/healthreform/upload/8348.pdf>

⁶ Beyond the services that state Medicaid programs are required to cover, states have the option to support additional services such as GME and receive matching federal funds for them.

⁷ Inpatient care payments by private insurers to teaching hospitals (that are greater than costs) indirectly help to support clinical training.

expand their Medicaid managed care programs.⁸ However, support for GME under managed care remains at risk. Not all states with Medicaid risk-based managed care programs provide GME support under managed care. While Medicaid managed care capitation rates may include historical payments for GME in many states, MCOs often are not bound to distribute these dollars to hospitals with clinical training programs or to sponsor training programs themselves.

Medicaid GME Payments: A Survey of State Medicaid Programs

In 2012, the Association of American Medical Colleges (AAMC) contracted with the author, an independent health workforce consultant, to survey state Medicaid programs to examine their policies for financing GME.⁹ In part, the intent of the study was to update earlier studies of state Medicaid GME policies (published in 1999, 2003, 2006, and 2010 respectively) for the AAMC that were conducted by the author and the National Conference of State Legislatures.

In the spring of 2012, an online questionnaire was developed and distributed to Medicaid agencies in each of the 50 states and the District of Columbia to identify each program's current policies and issues associated with GME payments. (*See Appendix for a copy of the survey instrument.*) All but one state Medicaid agency responded to the survey. However, corresponding data from the non-responding state was obtained through another source.¹⁰ Thus, the final count of state responses is 51.¹¹

This report reflects the climate for state Medicaid GME support as of 2012 and is intended to set a foundation for future analyses. Consequently, its content may not reflect any fiscal or policy changes that have occurred since completion of the survey.

Findings

As of 2012, 42 states and the District of Columbia provided GME payments under their Medicaid program (Table 1). Two of these states—**Montana** and **Vermont**—previously had reported ending GME support in 2009. Medicaid agencies in eight states did not pay for such costs; all of these states at one time had made GME payments under their Medicaid program. Two of the eight states—**California** and **New Hampshire**—discontinued GME payments within the past three years.¹²

Additionally, five states—Iowa, Michigan, Oregon, Pennsylvania, and Tennessee—in 2012 reported having recently considered ending GME Medicaid payments. All these states identified current budget shortfalls or cost controls as the rationale for considering discontinuation of GME payments.¹³

⁸ This does not include Medicaid enrollees in less comprehensive managed care arrangements, known as prepaid health plans. Only three states (Alaska, New Hampshire, and Wyoming) report that they do not have any Medicaid managed care. Of the 48 states with comprehensive managed care programs, 35 states and the District of Columbia report contracting with risk-based managed care organizations (MCOs), and 31 states report operating a primary care case management program. Although half of all Medicaid beneficiaries are enrolled in MCOs, payments to MCOs represent just 20 percent of total Medicaid spending on services. Most of these enrollees today are low-income children and parents, but states are increasingly moving beneficiaries with more complex needs into MCOs. <http://www.kff.org/medicaid/upload/8046-02.pdf> <http://www.kff.org/medicaid/upload/8380.pdf>

⁹ This study examines the special payments that state Medicaid programs make to teaching hospitals associated with their clinical care and teaching missions. The report is not intended to discuss disproportionate share payments or other special financing arrangements that Medicaid uses to support care to low-income populations.

¹⁰ Wisconsin Medicaid did not respond to the AAMC survey. However, at the consultant's request, corresponding survey data were obtained by the Wisconsin Hospital Association from the Wisconsin Medicaid agency for use in this report.

¹¹ No attempt was made to independently verify the results of this study.

¹² Vermont reinstated GME support in 2012 under a Medicaid State Plan Amendment pending federal approval. Alabama also reported in 2012 ending GME payments; the state did not respond to the survey in 2009. New Hampshire reported in 2009 to have recently considered ending GME support.

¹³ Michigan, Oregon, and Pennsylvania also reported in 2009 to have considered ending GME payments.

GME Payments under Fee-for-Service

Forty states and the District of Columbia reported making GME payments under their Medicaid fee-for-service (FFS) programs (Table 1). This equals the number of states that reported making GME payments under FFS in 2009, but represents a significant decline from 2005 when 46 states and the District of Columbia made GME payments under FFS (Table 14).

When asked how payments are calculated, 12 states out of the 40 states and the District of Columbia that help support GME under FFS said they used methods similar to those used under the Medicare program. This number is down from 2009, when 15 states and the District of Columbia reported using a Medicare-related methodology. **The remaining 28 states and the District of Columbia report using some “other method” for calculating GME payments, which was not specified in the survey.** Of these, six states and the District of Columbia used a per-resident method based on the teaching hospital’s share of total Medicaid revenues, costs or patient volume. Another three states used a modified Medicare methodology, and three states utilized a method involving a lump-sum amount. In addition, three states—Iowa, Montana, and New Jersey—reported making Medicaid GME payments to teaching hospitals from a state subsidy approved through state appropriations (Table 2).

The states (and the District of Columbia) that made GME payments under FFS distributed these payments using two methods. States are equally split between making GME payments through the teaching hospital’s per-case or per-diem rate (21 states and the District of Columbia) and a separate direct payment to these institutions (22 states). Three states report using both methods. Among these three states, **Kansas** makes GME payments to public teaching hospitals as part of the hospital per-diem rate; all other hospitals receive a supplemental quarterly payment for GME. **Kentucky** uses the hospital per-diem rate to pay for indirect GME costs, and a separate direct payment to reimburse for direct costs (Table 3).

GME Payment under Risk-Based Managed Care

Of the 36 states (and the District of Columbia) with risk-based Medicaid managed care programs,¹⁴ 65 percent—23 states and the District of Columbia—provided some level of GME support under the plans in 2012 (Table 1). These payments were made explicitly and directly to teaching programs, or indirectly as part of the risk-based MCO capitation rates.

Fourteen states and the District of Columbia made Medicaid GME payments explicitly and directly to teaching hospitals (or other teaching programs) under risk-based managed care (Table 4). This represents an increase from 2009 of two more states that made GME payments directly under capitated managed care. In 2002, 18 states “carved out” GME payments from MCO capitation rates (Table 14). The most common reasons cited (as specified in the survey) for Medicaid continuing to pay directly for GME under managed care include the desire to use Medicaid funds to advance state policy goals, the desire to help train the next generation of physicians who will serve Medicaid beneficiaries, and the view that GME is a public good (Table 4).

Most of these states used a method for calculating GME payments that was unspecified in the survey, although typically it involved a per-resident amount, lump sum, or variation of a Medicare FFS methodology. **New York** used a per-Medicaid discharge amount method, as well as payments under a hospital per-diem rate for services exempt from the per-case methodology. Otherwise, four states followed the Medicare FFS methodology, and another four states used a per-Medicaid discharge amount method (Table 5).

¹⁴ Risk-based managed care is defined as Medicaid’s use of capitated payments under contract to managed care organizations, and does not include any payments made under a state’s primary care case management program model of managed care. <http://www.kff.org/medicaid/upload/8220.pdf>

Another nine states recognized and included Medicaid GME payments in their capitated payment rates to managed care organizations (*Table 6*). This number is down slightly from the number of states providing such payments in 2009, and represents a significant decline from 1998 (*Table 14*). Five of the nine states (**Kansas, Kentucky, Michigan, Oregon, and Washington**) required MCOs to distribute these implicit payments in their negotiated rates to teaching hospitals (up from just two states in 2005). Of these 5 states, **Kansas, Michigan, and Oregon** provided MCOs a specific methodology for determining GME add-on payments. The other four of the nine states assumed the MCOs would distribute the payments to teaching programs.

The balance of states (10) with a Medicaid capitated managed care program did not leave GME historical payments in the base used for calculating MCO payments but supported GME under fee-for-service. For these states, the most common reasons reported were that Medicaid payment for GME under managed care is not a pressing policy issue among competing issues, and there is difficulty in determining a methodology to pay for GME under managed care (*Table 7*).

Training Institutions and Professions Eligible for GME Payments

Nearly all states that made GME payments reported that teaching hospitals were the primary training institutions to receive such payments. Four (mainly rural) states—**Kansas, Minnesota, Missouri, and West Virginia**—specify that teaching sites in non-hospital settings are also eligible.

Three states identified medical schools as eligible to receive GME payments. In **Tennessee** and **Oklahoma**, medical schools are the only training institutions allowed to receive Medicaid GME payments directly under managed care. Under **Minnesota's** managed care program, GME payments may go to schools of medicine, nursing, dentistry, and pharmacy; non-hospital training sites and other settings; and teaching hospitals.

Training programs for physician residents were the predominant entities eligible for Medicaid GME support. However, in 12 states, Medicaid either required or allowed the subsidization of other health profession training programs, or the agency made no distinction regarding which training programs could be subsidized (*Table 8*). Nine states explicitly required or allowed Medicaid GME support for graduate nursing programs.

GME Payments Linked to State Goals

More than two-thirds of states report having difficulty ensuring a sufficient supply of providers for their Medicaid beneficiaries.¹⁵ A new question on this survey asked states whether they linked Medicaid GME payments to a state policy goal of increasing the size of the physician workforce. **Twenty-two states made Medicaid GME payments with the expectation of producing more physicians** (*Table 9*).

Thirteen states placed explicit limits on the amount of Medicaid GME payments. This represents the same number of states reporting the use of such limits in 2009, but a decline in the number of states since 2005 (*Table 14*). These limits indicate persistent concerns with overall Medicaid spending levels as part of tight state budgets.

Medicaid GME Payment Amounts

Medicaid remained an important source of GME support. The amount of Medicaid GME payments is difficult to quantify precisely. This is due in part to the fact that teaching hospitals may also receive Medicaid disproportionate share (DSH) payments, and it is challenging to differentiate them from GME payments. In addition, states that include GME payments in their MCO rates may find it difficult to separately identify these payments.

¹⁵ <http://www.gao.gov/assets/650/649788.pdf>

Determining the level of GME payments even under the Medicaid fee-for-service program requires an extraordinary effort in a few states.

In 2012, 40 of the 42 states and the District of Columbia that support GME programs reported total Medicaid GME payments. In the remaining three states, consultant estimates of total GME payments were made in lieu of unreported data. Consultant-estimated payment amounts represented fewer than 3 percent of the nationwide GME payment total in 2012.

Assuming these limitations, **total Medicaid GME payments in 2012 by the states and the District of Columbia reached an estimated \$3.87 billion** (*Table 10*). These state-reported and consultant-estimated state GME payments reflect the following: 1) payments made under Medicaid FFS (\$2.32 billion); 2) payments made directly (explicitly) to teaching programs under managed care (\$1.29 billion); and 3) payments (implicitly) recognized and included in capitated rates to MCOs (\$264 million).

Total Medicaid support for GME continued to grow in 2012. In earlier AAMC surveys, Medicaid GME payments in 2009 were estimated at **\$3.78 billion**—much larger than the **\$2.3 to \$2.4 billion** estimate of total Medicaid GME payments reported in 1998.¹⁶

However, six states—Iowa, Michigan, Minnesota, Nebraska, New Mexico and South Carolina—reported in 2012 that they have explicitly reduced payments for GME. Another eight states reported that 2012 GME payment amounts were more than 10 percent less than those reported in 2009.

Across the states, GME payment amounts differed widely, ranging from more than \$1.8 billion in **New York** (an increase of \$290 million since 2009) to \$375,000 in **Alaska**. Combined, the 22 states with the lowest levels of Medicaid GME support represented just 7 percent of total support (*Table 10*). The 15 states with the highest levels of Medicaid GME spending represented about 85 percent of total payments (*Table 11*). Far and away, **New York's** Medicaid program spent the most of any state on GME in 2012—about 47 percent of the national total of state Medicaid GME payments. Nine other states—**Michigan, Virginia, Pennsylvania, North Carolina, Arizona, Washington, South Carolina, Missouri** and **Georgia**—each spent at least \$100 million.

Medicaid GME payments in 2012 on average represented 7.3 percent of total Medicaid inpatient hospital expenditures, as reported by the states. This percentage exceeds 2009 levels, but represents a significant decline since 2002 when GME payments were 8 to 9 percent of total Medicaid inpatient expenditures (*Table 14*). The proportion of Medicaid inpatient hospital spending devoted to GME varied widely from less than 1 percent to nearly 37 percent. Only the **District of Columbia** and two states—**New York** and **Vermont**—reported spending 20 percent or more of Medicaid inpatient hospital expenditures on GME; 15 states reported spending less than five percent (*Table 10*).

Medicaid GME Payments and State Teaching Hospital Capacity

The states ranking highest in Medicaid GME support only partly mirror the ranking of states with the largest number of teaching hospitals and medical residents. Just three of the top 10 states—**Michigan, New York**, and **Pennsylvania**—in total count of both teaching hospitals and medical residents have a similarly high ranking in the amount of total Medicaid GME payments. Meanwhile, three other states—**California, Illinois**, and **Massachusetts**—that rank in the top 10 in number of teaching hospitals and medical residents provide no payments under Medicaid for graduate medical education (*Tables 12 and 13*).

¹⁶ In contrast, Medicare GME payments have remained relatively constant since 1998 when Medicare imposed hospital-specific caps on the number of medical residents it would support.

Summary

After experiencing the impacts of the worst economic downturn since the Great Depression, state policy makers were finally beginning to see signs of economic recovery heading into FY 2013. Growth in total Medicaid spending and enrollment slowed substantially in 2012 and is expected to remain slow in 2013. In addition, most states will have the opportunity to benefit from enhanced federal support included in the Affordable Care Act's Medicaid expansion in 2014. However, significant uncertainty about future Medicaid funding remains, as several federal deficit reduction proposals call for major cuts in Medicaid spending. The outcome and impact of deficit reduction negotiations on Medicaid support for GME is unknown.

Highlights:

- Forty-two states and the District of Columbia made GME payments under their Medicaid program in 2012, nearly the same number as in 2009. **Three of the eight states that reported not making GME payments—California, Illinois and Massachusetts—are among the 10 states with the largest number of GME programs.**
- **An additional five states reported in 2012 that they had recently considered ending Medicaid GME payments.**
- Medicaid remains a major source of funding for GME. **In 2012, the overall level of support for GME continued to grow, reaching more than \$3.87 billion. This represented significant growth since 1998 when combined Medicaid GME support totaled an estimated \$2.3 to \$2.4 billion.** However, **six states reported in 2012 that they have explicitly reduced GME payments; another eight states reported their total 2012 GME payments were more than 10 percent less than 2009 levels.**
- **Under Medicaid fee-for-service, 40 states and the District of Columbia reported making GME payments,** equal to the number of states that reported making such payments in 2009.
- **Of the 36 states (and the District of Columbia) having risk-based Medicaid managed care programs, 65 percent—23 states and the District of Columbia—made 2012 GME payments under Medicaid managed care.** Of those, 14 states and the District of Columbia made Medicaid GME payments explicitly and directly to teaching hospitals; another nine states recognized and included such payments in MCO capitation rates.
- Although teaching hospitals remain the predominant recipients of Medicaid GME support, **medical schools** in three states—**Minnesota, Oklahoma and Tennessee**—are eligible to receive such payments directly.
- In 12 states, nurses and other health professions trainees, as well as medical residents, may have their graduate training subsidized by Medicaid.
- Medicaid programs in 22 states make GME payments with the expectation of producing more physicians.

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Table 1

Medicaid Payments for Graduate Medical Education (GME), 2012

STATE	Under Medicaid Fee-For-Service	Under Medicaid Managed Care
Alabama	NO	NO
Alaska	YES	Managed Care Not Implemented
Arizona	YES	YES
Arkansas	YES	NO*
California	NO	NO
Colorado	YES	YES
Connecticut	YES	NO ¹
Delaware	YES	GME Payments in MCO rates
District of Columbia	YES	YES
Florida	YES	NO
Georgia	YES	YES
Hawaii	YES	GME Payments in MCO rates
Idaho	YES	NO*
Illinois	NO	NO
Indiana	YES	YES
Iowa	YES	NO
Kansas	YES	YES ²
Kentucky	YES	GME Payments in MCO rates
Louisiana	YES	YES
Maine	YES	NO*
Maryland	YES	YES
Massachusetts	NO	NO
Michigan	YES	GME Payments in MCO rates
Minnesota	YES	YES
Mississippi	YES	NO
Missouri	YES	NO
Montana	YES	NO*
Nebraska	YES	YES
Nevada	YES	NO
New Hampshire	NO	Managed Care Not Implemented
New Jersey	YES	NO
New Mexico	YES	NO
New York	YES	YES
North Carolina	YES	NO*
North Dakota	NO	NO
Ohio	YES	GME Payments in MCO rates
Oklahoma	YES	YES
Oregon	YES	GME Payments in MCO rates
Pennsylvania	YES	NO
Rhode Island	NO	NO
South Carolina	YES	YES
South Dakota	YES	NO*
Tennessee	No Fee-for-Service System	YES
Texas	YES	NO
Utah	YES	NO
Vermont	NO	YES ³
Virginia	YES	YES
Washington	YES	GME Payments in MCO rates
West Virginia	YES	NO
Wisconsin	YES	GME Payments in MCO rates
Wyoming	NO	Managed Care Not Implemented

MCO: Managed Care Organization

* The state Medicaid program operates only a primary care case management form of managed care, which typically does not include payment for hospital-based services.

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

¹ **Connecticut** Medicaid no longer operates a capitated managed care program, effective January 2012.

² **Kansas** Medicaid makes managed care GME payments both directly to teaching programs and implicitly through capitation rates of MCOs.

³ **Vermont** reinstated GME support in 2012 under a Medicaid State Plan Amendment pending federal approval.

Table 2

Methods for Calculating Medicaid GME Payments under Fee-For-Service, 2012

STATE	Follow Medicare Methodology	Other Method
Alabama *	*	*
Alaska		X ¹
Arizona		X ²
Arkansas	X ³	
California	*	*
Colorado	X	
Connecticut	X	
Delaware	X	
District of Columbia		X ⁴
Florida		X ⁵
Georgia	X	
Hawaii		X ⁶
Idaho		X ⁷
Illinois *	*	*
Indiana		X ⁸
Iowa		X ⁹
Kansas	X	
Kentucky		X ¹⁰
Louisiana		X
Maine	X	
Maryland		X ¹¹
Massachusetts *	*	*
Michigan		X ¹²
Minnesota		X ¹³
Mississippi		X ¹⁴
Missouri		X ¹⁵
Montana		X ¹⁶
Nebraska	X	
Nevada		X ¹⁷
New Hampshire *	*	*
New Jersey		X ¹⁸
New Mexico		X ¹⁹
New York		X ²⁰
North Carolina	X	
North Dakota *	*	*
Ohio		X ²¹
Oklahoma		X ²²
Oregon	X	
Pennsylvania		X ²³
Rhode Island *	*	*
South Carolina		X ²⁴
South Dakota		X ²⁵
Tennessee *	*	*
Texas	X ²⁶	
Utah		X ²⁷
Vermont *	*	*
Virginia		X ²⁸
Washington	X	
West Virginia		X ²⁹
Wisconsin		X ³⁰
Wyoming *	*	*
TOTAL # STATES	12	29

* The Medicaid agency does not pay for graduate medical education under its fee-for-service program. Tennessee Medicaid does not operate a fee-for-service program.

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

¹ Lump sum (not-per-resident) amount based on teaching site's share of total Medicaid revenues or patient volume.

² Per-resident amount based on statewide average Medicaid costs.

³ Includes nursing costs.

⁴ Indirect GME costs are included in prospective base rates, and direct GME costs are paid as per case add-on.

⁵ GME payments are allocated based on total Medicaid costs divided by total Medicaid days. GME costs are allowable as part of total costs.

⁶ Percentage add-on to routine per-diem and ancillary per-discharge rate.

⁷ A per-resident amount determined as part of the cost settlement process.

⁸ Cost-per-day (per diem) calculated by dividing routine and ancillary medical education costs by total patient days.

⁹ The state legislature establishes a pool of money to be used for GME payments. The amount is apportioned to qualifying hospitals based on an allocation methodology.

¹⁰ Per-resident amount.

¹¹ Per-resident amount based on teaching site's share of total Medicaid revenues or patient volume.

¹² Medicaid pays GME from 2 funding pools. In pool 1, a hospital's GME share is based on its portion total adjusted FTEs (FTEs × case mix × Medicaid utilization). In pool 2, a hospital's share is based on its portion of total adjusted primary care FTEs (FTEs × Medicaid outpatient charges divided by total charges).

¹³ The Medical Education and Research Costs (MERC) fund, operated by the Minnesota Department of Health, makes payments by distributing available funds to training sites through sponsoring institutions, as an annual lump sum supplemental amount in proportion to Medicaid program volume. Clinical training sites report to MERC their trainee and faculty costs.

¹⁴ Payments are a "per inpatient per day" amount, which is a modification of the Medicare methodology. Pending legislative approval in 2013, hospital payments will change to an APR-DRG payment methodology; details on how GME payments will be made have not been finalized.

¹⁵ Medicaid calculates GME payments by determining the Medicaid GME cost per patient day based on 4th quarter prior fiscal year cost report and trending to current state fiscal year (SFY), and then multiplying by the estimated patient days for the SFY. Qualifying hospitals can also receive an enhanced GME payment paid annually, which represents the difference between the CPI indices used by Missouri Medicaid for the basis for its trends.

¹⁶ Under an intergovernmental transfer methodology, a state appropriation to the state university is transferred to Medicaid and matched with federal funds and paid directly to the teaching hospitals.

¹⁷ Per-resident amount multiplied by the market basket change and Medicare payment updated for IPPS; then multiplied by number of FTE residents, then multiplied by the Medicaid patient load.

¹⁸ GME payments are from a state subsidy approved through legislative appropriations.

¹⁹ Payments are made on a prospective basis as outlined in Medicaid policies.

²⁰ GME costs are calculated using a modified Medicare methodology using 2005 costs adjusted for statutorily allowed inflation.

²¹ A modified Medicare methodology is used to pay GME hospitals on a prospective basis.

²² Hospitals are allocated a pool of funds by resident-months weighted for Medicaid days and acuity.

²³ Eligible providers receive a percentage of funds allocated for GME payments (75%) based on inflation adjustments determined in hospital rate agreements.

²⁴ Cost based at 87.3% of Medicaid's portion of medical education costs.

²⁵ Lump sum amount.

²⁶ Per resident amount, as a supplemental program in which state teaching institutions provide their own state matching share. Medicaid's rate analysis does not determine the rationale for inclusion or exclusion of GME payments; this is determined through legislative authority.

²⁷ See State Plan, Attachment 4.19-A: http://www.health.utah.gov/medicaid/stplan/A_4-19-A.pdf

²⁸ Per resident amount is based on Medicaid base-year cost, adjusted for inflation to current year.

²⁹ Modified Medicare methodology.

³⁰ GME costs are a percentage add-on to the hospital rate based on the ratio of GME costs to total hospital operating costs.

Table 3

Methods for Distributing Medicaid GME Payments under Fee-For-Service, 2012

STATE	As Part of Hospital's Per-Case or Per-Diem Rate	As a Separate Direct Payment
Alabama*	*	*
Alaska	X	
Arizona		X
Arkansas		X
California*	*	*
Colorado	X	
Connecticut	X	
Delaware	X	
District of Columbia	X	
Florida	X ¹	
Georgia	X	X
Hawaii	X	
Idaho		X
Illinois*	*	*
Indiana	X	
Iowa		X
Kansas ²	X	X
Kentucky ³	X	X
Louisiana	X ⁴	
Maine		X
Maryland		X
Massachusetts*	*	*
Michigan		X
Minnesota	X	
Mississippi	X	
Missouri		X
Montana		X
Nebraska	X	
Nevada		X
New Hampshire	*	*
New Jersey		X
New Mexico		X
New York	X	
North Carolina	X	
North Dakota*	*	*
Ohio	X	
Oklahoma		X
Oregon		X
Pennsylvania		X
Rhode Island*	*	*
South Carolina	X	
South Dakota		X
Tennessee*	*	*
Texas		X
Utah		X
Vermont*	*	*
Virginia		X
Washington	X	
West Virginia	X	
Wisconsin	X	
Wyoming*	*	*
TOTAL # STATES	22	22

* The Medicaid agency does not pay for graduate medical education under its fee-for-service program. Tennessee Medicaid does not operate a fee-for-service program.

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

¹ As supplemental payments to statutory and family practice teaching hospitals, and other hospitals participating in GME consortiums, under the Disproportionate Share Hospital (DSH) program.

² Payments made to public teaching hospitals are part of the hospital's per-diem rate. Other hospitals receive a separate direct payment quarterly.

³ Payments for direct costs are made as a separate direct payment to hospitals. Payments for indirect costs are included in the hospital's per-diem rate.

⁴ Payments are included in a prospective per diem. Payments to state and children's hospitals are cost-based and are included in an interim per-diem rate and settled as a percentage of cost via cost report.

Table 4

States Making Medicaid GME Payments Directly to Teaching Programs under Managed Care, 2012

STATE	Rationale for Making Medicaid GME Payments Directly (Carve-Out) to Teaching Programs
Arizona	Desire to use Medicaid funds to advance state policy goals
Colorado	Follow Medicare to make explicit GME payments to teaching hospitals for Medicare managed care enrollees; Concern from teaching hospitals about losing GME payments; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
District of Columbia	Follow Medicare's decision to make explicit GME payments to teaching hospitals for managed care enrollees
Georgia	GME seen as a public good; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Indiana	Follow Medicare to make explicit GME payments to teaching hospitals for Medicare managed care enrollees
Kansas	GME seen as a public good; Follow Medicare to make explicit GME payments to teaching hospitals for Medicare managed care enrollees; Concern from teaching hospitals about losing GME payments; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Maryland	Desire to help train the next generation of physicians who will serve Medicaid beneficiaries; Desire to use Medicaid funds to advance state policy goals; Promote training of primary care physicians
Minnesota	GME seen as a public good; Follow Medicare to make explicit GME payments to teaching hospitals for Medicare managed care enrollees; Concern from teaching hospitals about losing GME payments; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
Nebraska	GME seen as a public good
New York	Concern from teaching hospitals about losing GME payments; GME seen as a public good; Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries; Follow Medicare to make explicit GME payments to teaching hospitals for Medicare managed care enrollees
Oklahoma	Desire to use Medicaid funds to advance state policy goals; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries
South Carolina	To pay the cost of medical education
Tennessee	GME seen as a public good; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries; Desire to use Medicaid funds to advance state policy goals; Concern from teaching hospitals about losing GME payments
Vermont	GME seen as a public good; Desire to help train the next generation of physicians who will serve Medicaid beneficiaries; Desire to use Medicaid funds to advance state policy goals
Virginia	Do not want managed care to disadvantage teaching hospitals

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

Table 5

Methods for Calculating Medicaid GME Payments Made Directly to Teaching Programs under Managed Care, 2012

STATE	Follow Medicare FFS Methodology	Per-Medicaid Discharge Amount	Other Method
Arizona			X ¹
Colorado			X ²
District of Columbia	X		
Georgia	X		
Indiana			X ³
Kansas	X		
Maryland			X
Minnesota			X ⁴
Nebraska		X	
New York		X	X ⁵
Oklahoma			X ⁶
South Carolina		X	
Tennessee			X ⁷
Vermont	X		
Virginia		X	

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

¹ Per-resident amount based on statewide average Medicaid costs.

² GME payments are calculated as a lump sum based on inpatient days and outpatient charges.

³ GME payments made on a cost-per-day (per-diem) basis; calculated by dividing routine and ancillary medical education costs by total inpatient days.

⁴ GME payments are part of a pool for which teaching facilities can apply annually and are based on Medicaid volume and number of trainees.

⁵ GME payments made on a per-diem basis for those services exempt from the DRG (per case) methodology.

⁶ Payments made quarterly directly to medical schools under contracts detailing certain required levels of participation in Medicaid.

⁷ Fixed annual amount of money divided among the state's four medical schools using a calculation factoring in the number of primary care residents to the total number of residents.

Table 6

States Recognizing and Including Medicaid GME Payments in Capitation Rates to Managed Care Organizations, 2012

STATE	Medicaid <u>Requires</u> MCOs to Distribute GME Payments to Teaching Hospitals	Medicaid <u>Assumes</u> MCOs Distribute GME Payments to Teaching Hospitals
Delaware		X
Hawaii		X
Kansas	X ¹	
Kentucky	X ²	
Michigan	X ³	
Ohio		X
Oregon	X ⁴	
Washington	X ⁵	
Wisconsin		X

MCOs = Managed Care Organizations

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

¹ MCOs are provided a specific methodology for determining GME add-on payments. Medicaid FFS provides the GME factors to apply to the peer group hospital rate. Payment is calculated as the peer group rate multiplied by the MSDRG weight for DRG.

² MCOs are not provided a methodology for determining GME add-on payments. MCO-specific methodologies are approved by Medicaid during contract negotiations.

³ MCOs are provided a specific methodology for determining GME add-on payments.

⁴ MCOs are provided a specific methodology for determining GME add-on payments. MCOs are directed to pay each hospital based on the amount of GME built into the plan's capitation rate.

⁵ MCOs are not provided a methodology for determining GME add-on payments. GME is not an add-on, but rather a component of the FFS inpatient and outpatient rates for teaching hospitals. Washington primarily pays using a DRG methodology for inpatient and APC for outpatient. MCOs mirror the FFS fee schedule, which includes the GME component.

Table 7

Reasons Given by States for Not Making Medicaid GME Payments under Managed Care¹, 2012

STATE*	Rationale for Not Making GME Payments Under Managed Care
Florida	Medicaid payment for GME under managed care is not necessary or appropriate
Iowa	Medicaid payment for GME under managed care is not needed given other federal funding; GME payments under managed care are not a pressing policy issue among many competing issues
Missouri	Medicaid payment for GME under managed care is not a pressing policy issue among many competing issues; Difficulty determining methodology to pay for GME under managed care
Nevada	Difficulty determining methodology to pay for GME under managed care
New Jersey	Difficulty determining methodology to pay for GME under managed care
New Mexico	Medicaid payment for GME under managed care is not a pressing policy issue among many competing issues; Difficulty determining methodology to pay for GME under managed care
Pennsylvania	An amount was added to fee-for-service GME payments to compensate for no longer including payment of GME costs under capitated managed care
Texas	*
Utah	GME payment under fee-for-service accounts for needs of entire state More straightforward to only pay under FFS
West Virginia	*

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

¹ Only states that at least make Medicaid GME payments directly to teaching programs under their fee-for-service programs **and** have implemented a capitated managed care program are included.

* State did not report a rationale for not making GME payments under managed care.

Table 8

Health Professions Eligible for Medicaid GME Payments, 2012

STATE	Medical Residents	Graduate Nurses	Other Professions
Alaska	X		
Arizona	X		
Arkansas	X		
Colorado	X	X	
Connecticut	X		
Delaware	X		
District of Columbia	X		
Florida	X		
Georgia	X		
Hawaii	X		
Idaho	X		
Indiana	X	X	X ¹
Iowa	X		X
Kansas	X		X
Kentucky	X		
Louisiana	X	X	X ²
Maine	X		
Maryland	X		
Michigan	X		
Minnesota	X	X	X ³
Mississippi	X	X	
Missouri	X		
Montana	X		
Nebraska	X		
Nevada	X		
New Jersey	X		
New Mexico	X		
New York	X		
North Carolina	X		
Ohio	X		X
Oklahoma	X		
Oregon	X		
Pennsylvania	X	X	
South Carolina	X	X	X ⁴
South Dakota	X		
Tennessee	X		
Texas ⁵			
Utah	X		
Vermont	X		
Virginia	X	X	X
Washington	X		
West Virginia	X		
Wisconsin	X	X	X

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

¹ Students in paramedical programs (e.g., emergency medical services, clinical pastoral education, radiology technology).

² Allowable programs per Medicare (e.g., medical technologists, radiology technologists).

³ Medical students, dental, pharmacy, chiropractic, and physician assistant students.

⁴ Laboratory personnel.

⁵ State did not provide a response to this question.

Table 9

States Linking Medicaid GME Payments to State Policy Goal of Producing More Physicians, 2012

STATE	Medicaid GME Payments Made with Expectation of Producing More Physicians in the State
Alaska	Yes
Arkansas	Yes
Arizona	Yes
Colorado	No
Connecticut	No
Delaware	No
District of Columbia	No
Florida	Yes
Hawaii	No
Idaho	Yes
Indiana	No
Iowa	Yes
Kansas	Yes
Kentucky	**
Louisiana	Yes
Maine	No
Maryland	**
Michigan	Yes
Minnesota	Yes
Mississippi	Yes
Missouri	No
Montana	Yes
Nebraska	No
Nevada	Yes
New Jersey	Yes
New Mexico	Yes
New York	Yes
North Carolina	Yes
Ohio	**
Oklahoma	Yes
Oregon	Yes
Pennsylvania	No
South Carolina	No
Tennessee	Yes
Texas	**
Utah	No
Vermont	Yes
Virginia	No
Washington	No
West Virginia	Yes
Wisconsin	**
TOTAL # of STATES	22

** State provided no response.

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

Table 10

Medicaid GME Payment Amounts, 2012¹

STATE	GME Payments (Explicit) Under Fee-for-Service (Millions of Dollars)	GME Payments Under Managed Care (Millions of Dollars)		Total Explicit GME Payments ² (Millions of Dollars)	Total GME Payments (Millions of Dollars)	Total GME Payments: % of Inpatient Hospital Expenditures	Total GME Payments: State Rank
		Implicit Payments ³	Explicit Payments ⁴				
Alabama*	*	*	*	*	*	*	*
Alaska	\$0.375	\$0	\$0	\$0.375	\$0.375	<0.1	43
Arizona	Unreported	\$0	Unreported	\$113.0	\$113.0	Unreported	6
Arkansas	\$9.0	\$0	\$0	\$9.0	\$9.0	1.2	33
California*	*	*	*	*	*	*	*
Colorado	Unreported	\$0	Unreported	\$5.4	\$5.4	Unreported	35
Connecticut ⁵	\$9.6	\$0	\$0	\$9.6	\$9.6	4.0	32
Delaware	\$1.9	\$3.3	\$0	\$1.9	\$5.2	6.5	38
District of Columbia	\$71.8	\$0	\$7.3	\$79.1	\$79.1	36.8	13
Florida ⁶	\$81.3	\$0	\$0	\$81.3	\$81.3	2.3	12
Georgia	\$87.9	\$0	\$13.0	\$100.9	\$100.9	Unreported	10
Hawaii	Unreported	Unreported	\$0	Unreported	\$0.92	2.4	42
Idaho	\$1.1	\$0	\$0	\$1.1	\$1.1	<0.1	40
Illinois* ⁷	*	*	*	*	*	*	*
Indiana	\$18.0	\$0	\$10.0	\$28.0	\$28.0	4.1	26
Iowa	\$23.9	\$0	\$0	\$23.9	\$23.9	6.6	28
Kansas	\$26.1	\$17.2	\$6.4	\$32.5	\$49.7	Unreported	17
Kentucky	\$6.2	\$30.0	\$0	\$6.2	\$36.2	Unreported	23
Louisiana	\$41.9	\$0	\$6.9	\$48.8	\$48.8	4.2	18
Maine	\$5.3	\$0	\$0	\$5.3	\$5.3	2.4	37
Maryland	Unreported	\$0	Unreported	\$42.5	\$42.5	Unreported	19
Massachusetts*	*	*	*	*	*	*	*
Michigan	\$63.1	\$100.0	\$0	\$63.1	\$163.1	8.1	2
Minnesota	\$16.2	\$0	\$23.9	\$40.1	\$40.1	2.8	20
Mississippi	\$25.0	\$0	\$0	\$25.0	\$25.0	4.0	27
Missouri	\$110.1	\$0	\$0	\$110.1	\$110.1	6.8	9
Montana	\$0.94	\$0	\$0	\$0.94	\$0.94	1.3	41
Nebraska	\$11.5	\$0	\$2.6	\$14.1	\$14.1	6.5	29
Nevada	\$10.3	\$0	\$0	\$10.3	\$10.3	3.4	31
New Hampshire*	*	*	*	*	*	*	*
New Jersey	\$90.0	\$0	\$0	\$90.0	\$90.0	Unreported	11
New Mexico	\$5.4	\$0	\$0	\$5.4	\$5.4	<0.1	35
New York	\$894.8	\$0	\$920.2	\$1,815.0	\$1,815.0	33.0	1
North Carolina	\$115.7	\$0	\$0	\$115.7	\$115.7	11.4	5
North Dakota*	*	*	*	*	*	*	*
Ohio	Unreported	Unreported	\$0	Unreported	\$70.4	Unreported	15
Oklahoma	\$16.2	\$0	\$57.2	\$73.4	\$73.4	5.9	14
Oregon	\$27.8	\$10.9	\$0	\$27.8	\$38.7	3.3	22

Table 10, continued on next page

Table 10, Medicaid GME Payment Amounts, 2012, *continued*

STATE	GME Payments (Explicit) Under Fee-for-Service (Millions of Dollars)	GME Payments Under Managed Care (Millions of Dollars)		Total Explicit GME Payments ² (Millions of Dollars)	Total GME Payments (Millions of Dollars)	Total GME Payments: % of Inpatient Hospital Expenditures	Total GME Payments: State Rank
		Implicit Payments ³	Explicit Payments ⁴				
Pennsylvania	\$124.2	\$0	\$0	\$124.2	\$124.2	Unreported	4
Rhode Island*	*	*	*	*	*	*	*
South Carolina	\$68.0	\$0	\$42.7	\$110.7	\$110.7	11.0	8
South Dakota	\$3.0	\$0	\$0	\$3.0	\$3.0	Unreported	39
Tennessee	\$0	\$0	\$50.0	\$50.0	\$50.0	6.2	16
Texas ⁵	\$32.0	\$0	\$0	\$32.0	\$32.0	Unreported	24
Utah	\$6.3	\$0	\$0	\$6.3	\$6.3	Unreported	34
Vermont	\$0	\$0	\$30.0	\$30.0	\$30.0	24.0	25
Virginia	\$83.2	\$0	\$58.8	\$142.0	\$142.0	Unreported	3
Washington	\$64.0	\$47.0	\$0	\$64.0	\$111.0	Unreported	7
West Virginia	\$11.4	\$0	\$0	\$11.4	\$11.4	7.0	30
Wisconsin ⁹	\$12.6	<u>\$27.0</u>	\$0	\$12.6	\$39.6	Unreported	21
Wyoming*	*	*	*	*	*	*	*
TOTALS OR AVERAGE	**	**	**	**	\$3.87 billion¹⁰	7.3%	**

* The Medicaid agency does not pay for GME.

** Totals cannot be calculated because of unreported data.

NOTES:

- **Underlined amounts are the consultant's estimates in lieu of unreported data.**
- **Arizona, Colorado, Hawaii, and Maryland** reported a total GME payment amount, but provided no specific breakdown amounts for FFS and/or managed care GME payments.
- **Ohio** did not report the GME payment amounts the state makes under its FFS and managed care programs. The estimate of total GME payments for Ohio is based on the state's total Medicaid inpatient hospital expenditures, which the state made available. A proportion of total GME payments for the states that reported such payments to the total Medicaid inpatient hospital expenditures reported by these states was calculated. This proportion—7.3 percent—was multiplied by the total Medicaid inpatient hospital expenditure amount for Ohio in 2011, (\$964.5 million), to arrive at an estimate (underlined) of total GME payments in the state.
- **Kansas** reported making explicit GME payments under both its FFS and managed care programs, but did not report the *implicit* amount paid under managed care, and accordingly, a *total* amount paid under FFS and managed care. An estimate of *implicit* GME payments under managed care was made. Assumptions used by the consultant in making the estimate are: The proportion of GME payments made under FFS for the 15 states that reported making GME payments under both FFS and managed care (excluding Kansas) to the total GME payments for these states was calculated. The FFS GME payment amount reported for Kansas was divided by this proportion—52.5 percent—to arrive at an estimate of total GME payments in Kansas. The FFS GME payment amount in Kansas was subtracted from this total GME payment amount to estimate the amount of GME payments (both explicit and implicit) made by Kansas under managed care. The amount for *explicit* GME payments under managed care reported by Kansas was then subtracted from this amount to determine an estimated amount for *implicit* GME payments made under managed care.

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

¹ The start and end date for each state's fiscal year varies. Not all states were able to report payment amounts for fiscal year 2012. States reporting payment amounts for 2011 include Alaska, Arkansas, Arizona, Delaware, District of Columbia, Georgia, Indiana, Kentucky, Maine, Mississippi, Nebraska, New York, North Carolina, Pennsylvania, and South Carolina. Colorado and Virginia reported payment amounts for 2010. Connecticut reported payment amounts for 2008. Total payment amount estimates for Ohio are for 2011 and for 2012 in Wisconsin.

² The total amount of GME payments made directly to teaching programs under both fee-for-service and managed care, including state-reported and consultant-estimated amounts.

³ Implicit GME payments are those recognized and included in capitation rates to managed care organizations.

⁴ Explicit GME payments are those made directly to teaching programs under managed care.

⁵ Medicaid no longer operates a capitated managed care program, effective January 1, 2012.

⁶ Medicaid also makes supplemental payments to physicians employed by or under contract with public and private medical schools for reimbursement of costs related to the supervision/education of physician residents and interns working in teaching hospitals. In fiscal year 2012, the amount of these payments was \$219.3 million.

⁷ Although Illinois Medicaid ceased making GME payments to all teaching hospitals in 1995, the state legislature provides an annual GME-related appropriation to 10 teaching hospitals. (Personal communication with D. Jenkins of Illinois Medicaid, April 2012.)

⁸ Medicaid reimburses five state-owned teaching hospitals for their GME costs in which each state facility provides their own state matching share with funds provided by the state legislature.

⁹ Medicaid did not respond to the AAMC survey. However, corresponding survey data on FFS payments were collected by the Wisconsin Hospital Association (WHA) from Wisconsin Medicaid and shared with the consultant for this report. In lieu of unreported GME payments under managed care, the consultant (with input from WHA) determined an estimated amount based on a proportional increase in managed care enrollment since the 2009 survey, which is underlined. (Personal communication with B. Potter of WHA, June–July 2012.)

¹⁰ The national amount does not precisely reflect the total of individual state amounts due to rounding.

Table 11

Medicaid GME Payment Amounts by the Top 15 States, 2012¹

STATE	Total GME Payments Under Fee-for-Service & Managed Care (Millions of Dollars)	GME Payments Under Managed Care (Millions of Dollars)	
		Implicit Payments ²	Explicit Payments ³
New York	\$1,815.0	\$0	\$920.2
Michigan	\$163.1	\$100.0	\$0
Virginia	\$142.0	\$0	\$58.8
Pennsylvania	\$124.2	\$0	\$0
North Carolina	\$115.7	\$0	\$0
Arizona	\$113.0	\$0	Unreported
Washington	\$111.0	\$47.0	\$0
South Carolina	\$110.7	\$0	\$42.7
Missouri	\$110.1	\$0	\$0
Georgia	\$100.9	\$0	\$13.0
New Jersey	\$90.0	\$0	\$0
Florida*	\$81.3	\$0	\$0
District of Columbia	\$79.1	\$0	\$7.3
Oklahoma	\$73.4	\$0	\$57.2
Ohio	<u>\$70.4</u>	Unreported	\$0

* **Florida** Medicaid also makes supplemental payments to physicians employed by or under contract with public and private medical schools for reimbursement of costs related to the supervision/education of physician residents and interns working in teaching hospitals. In fiscal year 2012, the amount of these payments was \$219.3 million.

NOTES:

- Underlined amounts are the consultant's estimates in lieu of unreported data.
- **Ohio** did not report the GME payment amounts the state makes under its FFS and managed care programs. The estimate of total GME payments for Ohio is based on the state's total Medicaid inpatient hospital expenditures, which the state made available. A proportion of total GME payments for the states that reported such payments to the total Medicaid inpatient hospital expenditures reported by these states was calculated. This proportion—7.3 percent—was multiplied by the total Medicaid inpatient hospital expenditure amount for Ohio in 2011, (\$964.5 million), to arrive at an estimate (underlined) of total GME payments in the state.

SOURCE: A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

¹ The start and end date for each state's fiscal year varies. Not all states were able to report payment amounts for fiscal year 2012. States reporting payment amounts for 2011 include Alaska, Arkansas, Arizona, Delaware, District of Columbia, Georgia, Indiana, Kentucky, Maine, Mississippi, Nebraska, New York, North Carolina, Pennsylvania, and South Carolina. Colorado and Virginia reported payment amounts for 2010. Connecticut reported payment amounts for 2008. Total payment amount estimates for Ohio are for 2011 and for 2012 in Wisconsin.

² Implicit GME payments are those recognized and included in capitation rates to managed care organizations.

³ Explicit GME payments are those made directly to the teaching programs under managed care.

Table 12

Medicaid GME Payments in States with the Largest Number of Teaching Hospitals, 2012

STATE	Number of Teaching Hospitals ¹	Provide GME Payments	Total Medicaid GME Payments (Millions of Dollars)	Average Medicaid GME Payments Per Hospital (Millions of Dollars) ²	Total Medicaid GME Payments as % of Inpatient Hospital Expenditures	Medicaid GME Payment Rank
California	97	No	\$0	--	--	--
New York	87	Yes	\$1,815.0	\$20.86	33.0	1
Pennsylvania	63	Yes	\$124.2	\$1.97	Unreported	4
Ohio	57	Yes	<u>\$70.4</u>	\$1.23	Unreported	15
Illinois	54	No	\$0	--	--	--
Michigan	52	Yes	\$163.1	\$3.14	8.1	2
Texas	52	Yes	\$32.0	\$0.62	Unreported	24
New Jersey	38	Yes	\$90.0	\$2.37	Unreported	11
Florida	35	Yes	\$81.3	\$2.32	2.3	12
Massachusetts	28	No	\$0	--	--	--

¹ A "teaching" hospital is defined as a hospital that reports resident full-time equivalents (FTEs) on its Medicare hospital cost report. Hospitals with fewer than five FTE residents and interns were excluded.

² Not all teaching hospitals in each state may receive Medicaid GME payments.

NOTES:

Underlined amounts are the consultant's estimates in lieu of unreported data.

- **Ohio** did not report the GME payment amounts the state makes under its FFS and managed care programs. The estimate of total GME payments for Ohio is based on the state's total Medicaid inpatient hospital expenditures, which the state made available. A proportion of total GME payments for the states that reported such payments to the total Medicaid inpatient hospital expenditures reported by these states was calculated. This proportion—7.3 percent—was multiplied by the total Medicaid inpatient hospital expenditure amount for Ohio in 2011 (\$964.5 million) to arrive at an estimate (underlined) of total GME payments in the state.
- Although **Illinois** Medicaid ceased making GME payments to all teaching hospitals in 1995, the state legislature provides an annual GME-related appropriation to 10 teaching hospitals. (Personal communication with D. Jenkins of Illinois Medicaid, April 2012.)
- **Texas** Medicaid only reimburses its five state-owned teaching hospitals for their GME costs. Each of these hospitals provides its share of funds to match dollars appropriated by the state legislature.
- **Florida** Medicaid also makes supplemental payments to physicians employed by or under contract with public and private medical schools for reimbursement of costs related to the supervision/education of physician residents working in teaching hospitals. In FY 2012, the amount of these payments was \$219.3 million.

SOURCES: Association of American Medical Colleges analysis of FY 2010 American Hospital Association data.

A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

Table 13

Medicaid GME Payments in States with the Largest Number of Medical Residents, 2012¹

STATE	Number of Medical Residents	Provide GME Payments	Total Medicaid GME Payments (Millions of Dollars)	Medicaid GME Payment Rank
New York	15,713	Yes	\$1,815.0	1
California	9,875	No	\$0	--
Pennsylvania	7,645	Yes	\$124.2	4
Texas	7,146	Yes	\$32.0	24
Illinois	5,932	No	\$0	--
Ohio	5,606	Yes	<u>\$70.4</u>	15
Massachusetts	5,475	No	\$0	--
Michigan	4,869	Yes	\$163.1	2
Florida	3,588	Yes	\$81.3	12
North Carolina	3,039	Yes	\$115.7	5

NOTES:

Underlined amounts are the consultant's estimates in lieu of unreported data.

- **Texas** Medicaid only reimburses its five state-owned teaching hospitals for their GME costs. Each of these hospitals provides its share of funds to match dollars appropriated by the state legislature.
- Although **Illinois** Medicaid ceased making GME payments to all teaching hospitals in 1995, the state legislature provides an annual GME-related appropriation to ten teaching hospitals. (Personal communication with D. Jenkins of Illinois Medicaid, April 2012.)
- **Ohio** did not report the GME payment amounts the state makes under its FFS and managed care programs. The estimate of total GME payments for Ohio is based on the state's total Medicaid inpatient hospital expenditures, which the state made available. A proportion of total GME payments for the states that reported such payments to the total Medicaid inpatient hospital expenditures reported by these states was calculated. This proportion—7.3 percent—was multiplied by the total Medicaid inpatient hospital expenditure amount for Ohio in 2011 (\$964.5 million) to arrive at an estimate (underlined) of total GME payments in the state.
- **Florida** Medicaid also makes supplemental payments to physicians employed by or under contract with public and private medical schools for reimbursement of costs related to the supervision/education of resident physicians and interns working in teaching hospitals. In FY 2012, the amount of these payments was \$219.3 million.

SOURCES: *Journal of the American Medical Association*, Appendix II (Vol. 308, No.21), December 2012, pages 2271–2272. A 2012 survey of state Medicaid agencies by Tim M. Henderson, M.S.P.H., consultant to the Association of American Medical Colleges.

¹ Number of resident physicians on duty as of December 31, 2011.

Table 14

Trends in State Medicaid GME Payments, 1998–2012

INDICATOR	2012	2009	2005	2002	1998
Number of States and DC Making GME Payments	43	42 ¹	48	48	46
Number of States and DC Making GME Payments Under <i>Fee for Service</i>	41	41	47	47	44
Number of States and DC Making GME Payments Explicitly and Directly to Teaching Hospitals Under <i>Managed Care</i>	15	13	15	18	17
Number of States and DC Recognizing and Including GME Payments in the Capitated Payment Rates to Managed Care Organizations	9	11	10	10	17
Number of States and DC Linking GME Payments to the Production of Physicians	22	*	*	*	*
Number of States and DC with Explicit Limits on Medicaid GME Payments	13	13	16	15	9
Medicaid GME Payments as a Percentage of Total Medicaid Inpatient Hospital Expenditures	7.3%	6.6%	7.0%	8–9%	7–8%

* For these years, a different question was asked: "Are Medicaid GME payments linked to explicit state physician workforce or related policy goals?" Ten to eleven states consistently responded 'yes' to the question.

SOURCES:

From a survey of state Medicaid agencies by: 1) Tim M. Henderson, MSPH, consultant to the Association of American Medical Colleges in 2012, 2009 and 2006, and 2) the National Conference of State Legislatures for the Association of American Medical Colleges in 2003 and 1999.

¹ Alabama Medicaid did not respond to the survey.

Medicaid GME Survey Instrument



MEDICAID PAYMENT POLICY: GRADUATE MEDICAL EDUCATION

State: _____ Date Completed Survey: _____

Respondent Name/ Title: _____ Phone #: _____

DEADLINE TO RETURN COMPLETED SURVEY: _____

Please Return by e-mail: TimMHend@aol.com [to: Tim Henderson, Consultant to Association of American Medical Colleges]

FEE-FOR-SERVICE PAYMENTS

1. Under your fee-for-service (FFS) system, does Medicaid pay hospitals (or other entities that incur teaching costs) for graduate medical education (GME), or otherwise provide explicit added payments to these hospitals or other teaching entities?

____ YES ____ NO ____ PRESENTLY, WE DON'T OPERATE A FEE FOR SERVICE SYSTEM
(Answer 1a) (Answer 1b) (If you answered this response, proceed to Question 5.)

- a. If YES, describe the rationale as you understand it for making these GME payments:

(Check all that apply)

____ GME seen as a public good;
____ Follow Medicare's decision to make explicit GME payments to teaching hospitals for Medicare beneficiaries;
____ Desire to use Medicaid funds to advance state health policy goals;
____ Desire to help train the next generation of physicians who will serve Medicaid beneficiaries;
____ Other (Describe: _____)

- b. If NO, describe the rationale as you understand it for not making GME payments:

(Check all that apply)

____ Medicaid payment for GME is not necessary or appropriate;
____ GME payments are not a pressing policy issue among many competing issues;
____ Medicaid historically paid for GME, but budget shortfalls or cost controls have necessitated ending payments;
____ Other (Describe: _____)

If you answered Question 1b., proceed to Question 5.

2. What institutions are eligible to receive GME payments under Medicaid FFS?

(Check all that apply)

____ Teaching hospitals;
____ Teaching sites in non-hospital patient care settings (such as ambulatory sites, managed care plans, etc.);
____ Medical schools;
____ Other institutions (Specify: _____)

3. In making payments for GME costs, how does your Medicaid FFS system:

a. Calculate Payments

(Check all that apply)

☐ Follow Medicare methodology;

☐ Other, Please describe _____)

b. Distribute Payments

(Check all that apply)

☐ As part of the hospital's per-case or per-diem rate;

☐ As a separate direct payment (monthly, quarterly, etc.);

☐ Other (Specify: _____)

4. Under your FFS system, do GME payments cover training costs for:

(Check all that apply)

☐ Physician Residents

☐ Graduate Nursing Students

☐ Other Health Professional Trainees (Specify: _____)

MEDICAID MANAGED CARE PAYMENTS

5. Does your Medicaid program operate a managed care system?

☐ YES

☐ NO

If you answered NO, proceed to [Question 11](#).

6. Under your Medicaid managed care system, are explicit GME payments made to teaching hospitals (or other entities that incur teaching costs)?

☐ YES

☐ NO

(Answer 6a)

(Answer 6b)

a. If YES, describe the rationale as you understand it for making these GME payments:

(Check all that apply)

☐ GME seen as a public good;

☐ Follow Medicare's decision to make explicit GME payments to teaching hospitals for managed care enrollees;

☐ Concern from teaching hospitals about losing GME payments;

☐ Desire to use Medicaid funds to advance state policy goals;

☐ Desire to help train the next generation of physicians who will serve Medicaid beneficiaries;

☐ Other (Describe: _____)

b. If NO, describe the rationale as you understand it for not making GME payments:

(Check all that apply)

☐ Medicaid payment for GME under managed care is not necessary or appropriate;

☐ GME payments under managed care are not a pressing policy issue among many competing issues;

☐ Difficulty determining methodology to pay for GME under managed care;

☐ Opposition by managed care plans to having GME payments go to teaching hospitals;

☐ Medicaid historically paid for GME, but recent budget shortfalls or cost controls no longer allow payment;

☐ Other (Describe: _____)

If you answered Question 6b., proceed to [Question 11](#).

7. In making payments for GME costs,— either:

- directly to teaching hospitals (or other entities) **OR**
- as part of payments to managed care plans for them to pass on to teaching hospitals (or other entities),

How does your Medicaid managed care program calculate GME payments?

(Check all that apply)

- ☐ Follow Medicare FFS methodology;
- ☐ On a per Medicaid managed care discharge basis;
- ☐ Payment included in capitation and negotiated by the provider
- ☐ Other (Specify: _____)

8. Under managed care, how does your Medicaid program distribute GME payments to teaching hospitals or other entities?

(Check all that apply)

- a. ☐ Medicaid makes a separate direct payment (per-case or per-diem, monthly, quarterly, etc.) to the hospital or other teaching entity
- b. ☐ Medicaid **requires** managed care organizations (MCOs) to pay the hospital (or other teaching entity) for GME costs as part of the hospital's per-case or per-diem rate;

If so, check one of the following:

- ☐ Medicaid provides MCOs a specific methodology for determining GME add-on payments;
- ☐ Medicaid does **not** provide MCOs a methodology for determining GME add-on payments.

Explain: _____

- c. ☐ Medicaid **assumes** MCOs reflect GME costs in their payments to hospitals (or other teaching entities), **but** does **not** require them to do so.

- d. ☐ Other (Specify: _____)

9. What institutions are eligible to receive GME payments under Medicaid managed care?

(Check all that apply)

- ☐ Teaching hospitals;
- ☐ Teaching sites in non-hospital patient care settings (such as ambulatory sites, managed care plans, etc.);
- ☐ Medical schools;
- ☐ Other institutions (Specify: _____)

10. Under Medicaid managed care, do GME payments help cover training costs for:

(Check all that apply)

- ☐ Physician Residents
- ☐ Graduate Nursing Students
- ☐ Other Health Professional Trainees (Specify: _____)

11. In the past year, has your Medicaid program considered discontinuing explicit payments for GME under either FFS or managed care?

☐ YES

☐ NO

☐ No GME Payments Are Made Under FFS or Managed Care

(Answer 11a and 11b)

(If you answered this last response, you have completed the survey. Thank you.)

a. If YES, describe the rationale for considering discontinuation of GME payments:

(Check all that apply)

☐ Medicaid payment for GME is no longer necessary or appropriate;

☐ GME payments are no longer an important policy issue among many competing issues;

☐ Current budget shortfalls or cost controls may necessitate ending payments;

☐ Opposition by managed care plans to having GME payments go to teaching hospitals;

☐ Other (Describe: _____)

b. If YES, by how much?

\$ _____ or _____ %

12. In the past year, has your Medicaid program explicitly reduced payments for GME?

☐ YES

☐ NO

(Answer 12a)

a. If YES, by how much?

\$ _____ or _____ %

USE OF GME PAYMENTS TO ACHIEVE STATE POLICY GOALS

13. Are Medicaid GME payments (under either FFS or managed care) made with the expectation of producing more physicians for your state?

☐ YES

☐ NO

14. Has your Medicaid program:

(Check all that apply)

☐ Limited/capped the # of residency positions or health professional trainees that qualify for Medicaid GME payments;

☐ Limited/capped the total Medicaid GME funding available each year;

☐ We have no such measures.

MEDICAID GME PAYMENT AMOUNTS

15. Please provide your best dollar estimate of the following:

- a. Your Total Medicaid GME Payments (*federal and state share*) for FY 2012: (or most recent FY available)
Include payments to public and private teaching hospitals.

(Complete all that apply)

Under Fee for Service (FFS): \$ _____

Under Managed Care (MC): \$ _____

FFS/MC Combined: \$ _____

For FY (if not 2012): _____

- b. Your FFS/MC Combined Medicaid GME Payments are:

_____ % of Total Medicaid expenditures

_____ % of Inpatient Hospital Medicaid expenditures

THANK YOU FOR YOUR ASSISTANCE.

YOU WILL RECEIVE A COPY OF THE SURVEY RESULTS ONCE THEY ARE REPORTED.

**NOTE: PLEASE PROVIDE DOCUMENTATION (preferably weblinks)
OF EXISTING REGULATIONS OR POLICIES GOVERNING GME PAYMENTS.**



**Association of
American Medical Colleges**

2450 N Street, N.W., Washington, D.C. 20037-1127

T 202 828 0400 **F** 202 828 1125

www.aamc.org